

CLINICAL EVALUATION-ADULTS

The Purpose of the Clinical Evaluation is to document the diagnosis, duration, and disability in sufficient detail to establish target population eligibility and level of need for mental health services.

Key symptoms and functional behaviors are to be identified in sufficient detail so that the impact on the consumer's functioning can be judged independently by an outside reviewer. Sufficient detail means the frequency of the behavior, duration of behavior, intensity of behavior, and the impact of the symptoms and behavior on daily functioning.

This evaluation is to be completed by a Board Certified Social Worker or a Licensed Professional Counselor and a licensed Psychologist or Psychiatrist, or by a licensed Psychologist or Psychiatrist. Parts X and XI MUST be completed by a licensed Psychologist or Psychiatrist. The evaluation must be legible.

I. IDENTIFYING INFORMATION:

- A. Name:
- B. Address:
- C. Date of birth: D. Age: E. Sex: F. Race:
- G. Social Security Number:
- H. Next of Kin/Relation:
- I. Source(s) of Information, if other than consumer (attach copies of latest documents used to complete this evaluation):

II. MENTAL HEALTH:

Describe this life area, to include at least the following:

- A. Present Illness:
 - 1. Chief complaint of consumer:

2. Presenting Problems (Within the last 6 months)
- a) This section should describe in detail **specific behavior** which impacts the individual=s functioning in the home, job site or community. This description should include the frequency and severity of the behavior.

| SUICIDE ATTEMPT DATES | METHOD | TREATMENT OBTAINED | CAUSE OF ATTEMPT |
|-----------------------|--------|--------------------|------------------|
| | | | |
| | | | |
| | | | |

3. Date of onset and course of illness:
4. Precipitating circumstances, stressors or conflicts:
5. Family or significant other's description of the problems:
6. Current psychotropic medications:

- B. Past Psychiatric History
1. Premorbid functioning level:

2. Previous Mental Health Treatment (Where, Date of Admit, Date of Discharge, Diagnosis):

| WHERE | DATE OF ADMIT | DATE OF DISCHARGE | DIAGNOSIS AND RESPONSE TO TREATMENT |
|-------|---------------|-------------------|-------------------------------------|
| | | | |
| | | | |
| | | | |

3. Response to previous psychotropic medications and why they were discontinued (Untoward responses and treatment response):

C. Special Treatment Issues:

1. Chronic non-compliance _____, specify any barriers to consumer/family engaging in treatment, such as transportation, religious beliefs, cultural issues:
2. Dually diagnosed (MI/MR, MI/SA); must document that mental illness is the primary disorder

D. Alcohol and Drug User History:

1. Describe the individual=s alcohol and drug use history including the date of onset, the type of drug used, the amount and frequency of usage and the date of last usage.
2. Excessive usage of caffeine/nicotine:
3. Medical problems associated with alcohol/drugs:

5. Preoccupation with usage: Yes _____ No _____

6. Legal issues associated with substance abuse:

E. Family History of Psychiatric Illness:

1. Family members (specify) who have had psychiatric problems and diagnosis:

2. Family members (specify) who have had substance abuse problems:

3. Family members (specify) who have attempted/committed suicide:

F. Legal Issues:

1. Current legal problems:

2. Current charges:

3. Pending court dates:

4. History of previous arrests and convictions:

III. PHYSICAL HEALTH:

Describe this life area, to include at least the following:

A. Current Physical Health

1. Current primary care physician (note multiple physicians, if applicable):

2. Current medical treatment:

3. Current medical medications:

B. Serious and/or Multiple Physical Health Problems:

C. Pertinent Injuries (such as head trauma), Illnesses (such as epilepsy or metabolic disorders) or Surgeries:

D. HIV Risk Factors:

E. Tardive dyskinesia (results of AIMs test), if applicable:

F. Allergies:

IV. FAMILY/SOCIAL RELATIONS/NATURAL SUPPORTS:

Describe this life area, to include at least the following:

A. Consumer history:

1. History of any birth abnormalities, developmental disabilities /delays:

2. Abuse/Neglect issues:

B. Constellation of Family:

1. Who is present in the residence (Names, Ages, Relationships):

2. Marriages:

3. Number of Children:

4. Consumer's relationship with Family:

5. Amount of Family Support available to consumer:

C. Social/Peer Group:

1. Description of friendships, peer group, or social environment:

2. Level of social interaction with peers:

D. Religion:

1. Current religion:

2. Significance of religion in consumer's life:

E. Community/Natural Supports:

1. If community/natural supports have been used, describe consumer's response to services:

V. BASIC NEEDS:

Address consumer's ability to provide for or be provided with each basic need including shelter, food, clothing, safety, transportation, self care and community living skills.

VI. EMPLOYMENT:

Describe this life area, to include at least the following:

A. Employment history:

1. Type job:

2. Job performance:

3. Response to authority:

4. Job skills:

5. Describe pattern of past jobs:

B. If unemployed, reasons for unemployment:

D. List any job training/job development activities consumer is utilizing:

C. Military Service History:

1. Branch of Service:
2. Duration of service:
3. Type of discharge:
4. Combat history: Yes _____ No _____
5. Any service connected psychiatric disabilities:
6. Any major problems encountered in the service, including substance abuse:

VII. EDUCATION:

Describe this life area, to include at least the following:

- A. Highest educational level achieved:
- B. Performance in school:
- C. History of regular or special education interventions:

VIII. RECREATIONAL/LEISURE:

Describe this life area, to include at least the following:

A. List hobbies or interests:

IX. FINANCIAL:

Describe this life area, to include at least the following:

A. Current monthly income:

B. Source of income:

If receiving Social Security Disability Insurance/SSI, List disability:

C. Household income:

D. Consumer's ability to manage money:

The following 2 sections are ONLY to be completed by a licensed psychologist or psychiatrist

X. MENTAL STATUS EXAMINATION: as observed on the basis of face to face contact with the consumer):

1. Appearance:

2. Alertness:

- 3 Attitude:
4. Attention span:
5. Speech:
6. Non-verbal behavior:
7. Mood:
8. Affect:
9. Thought process:
10. Thought content; suicidal, homicidal, delusional, unusual preoccupations:
11. Perception; hallucinations, illusions:

12. Orientation/sensorium; person, place, date:
13. Memory; recent and remote (specify basis for judgements):
14. Intellectual functioning (specify basis for judgements):
15. Insight/judgement:
16. Rapport:

XI. DIAGNOSIS:

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V:

I certify that I have personally completed the face-to-face evaluation and provided the information contained in this clinical evaluation:

Evaluator's signature

License number

Date

Evaluator=s name

I certify that I have personally completed the face-to-face mental status examination and provided the diagnosis based upon a review of all information contained in this clinical evaluation:

Psychologist/psychiatrist's signature

License number

Date

Print Psychologist/Psychiatrist's Name

1/17/96